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Racism and health care: Experiences of Latinx immigrant women in NYC during COVID-19

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ABSTRACT

The COVID-19 pandemic has disproportionately affected minoritized racial groups, especially Latinx immigrants, evidenced by the high rates of COVID-19 infections, hospitalizations, and deaths among this population. With increasing xenophobia and anti-immigrant sentiment in parallel to the pandemic, it is critical to understand the perspectives of Latinx populations. This study explores Latinx immigrant women's perceptions of racism and xenophobia in their health care experiences in New York City (NYC) during the COVID-19 pandemic and, further, seeks to understand the role of perceived discrimination in health care settings and on health care access. Data were analyzed using a constant comparative method of analysis from twenty-one in-depth interviews conducted with foreign-born women in the five boroughs of New York City from diverse countries across Latin America. Four central themes emerged including: structural inequalities, discriminatory health care experiences, victimization in public institutions, and overcoming discrimination in health care settings. Latinx immigrant women described the ways in which perceptions and experiences of discrimination shaped their capacity to address health-related needs during the COVID-19 pandemic. This study provides evidence to a growing body of literature suggesting that structural racism and xenophobia and perceptions of anti-immigrant discrimination, including resulting structural inequalities, may have a negative effect on individuals' ability to access and engage the health care system, resulting in avoidance of health care services – a critical need during a global pandemic. Scholars, policymakers, and practitioners alike should be mindful of how racism and xenophobia shape Latinx immigrant communities' engagement with the health care system.

1. Introduction

The COVID-19 pandemic has disproportionately affected historically underserved populations in the United States, particularly low-income populations and minoritized racial and ethnic groups (Bhala et al., 2020; Chowkwanyun & Reed, 2020; Greenaway et al., 2020; Kantamneni, 2020; Lopez et al., 2021). Over 46.7 million immigrants currently live in the United States, and 11 million of these immigrants are undocumented (Clark et al., 2020). A majority of immigrants are from Latin America, including 28% from Mexico and 24% from other Latin American countries (Szaflarski & Bauldry, 2019). Due to longstanding structural inequities and xenophobic immigration policies, immigrant communities have been facing the worst consequences of the pandemic (Desai & Samari, 2020; Page et al., 2020; Wilson & Stimpson, 2020). Latinx immigrants, in particular, were posed to experience disparate health impacts from COVID-19 (Macias Gil et al., 2020). More than 56%

of Latinx immigrants in the U.S. stated either a family member or close relative of theirs has been hospitalized or died from COVID-19, compared to 48% of U.S. born participants (Noe-Bustamante et al., 2021). In New York City (NYC), Latinx populations, including immigrants and U.S born individuals, are 1.4 times more likely to be infected with COVID-19, and two times more likely to be hospitalized from COVID-19 than non-Hispanic whites (Ong et al., 2021).

While it is asserted that immigrants enter the U.S. with better health compared to U.S. natives, research has shown that their health often deteriorates the longer they reside in the U.S. (Acevedo-Garcia & Bates, 2008; Castañeda et al., 2015; Crimmins et al., 2007; Franzini et al., 2001). Such a decline in immigrant health outcomes has been attributed to several multilevel factors, including health systems, interpersonal dynamics, access to resources, and individual behaviors, but xenophobia, or exclusion and discrimination of others based on national origin, which includes structural racism as well as perceived discrimination is often

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overlooked in the U.S. immigrant experience (Dennis et al., 2021; Samari et al., 2021; Viruell-Fuentes et al., 2012). Racism has long been linked to greater health disparities (Gee & Ford, 2011; Williams et al., 1997), only to be exacerbated by COVID-19 (Zalla et al., 2021). Experiences with structural and interpersonal racism are known to lead to poor mental health and physical health outcomes (Ayón, 2015; Devakumar et al., 2020; Williams, 2012). Racism and xenophobia are primary drivers of anti-immigrant sentiments and the resulting health inequities and outcomes (Suleman et al., 2018). Similar to any minoritized population, immigrants experience this discrimination across several social determinants of health and domains of life, including the workplace and in education, and in accessing, receiving, and utilizing health care services (Hill et al., 2021; Wallace et al., 2019).

Under the Trump administration, structural xenophobia played a significant role in undermining immigrant populations' ability to seek health care (Fleming et al., 2019). Not only did the administration promote anti-immigrant rhetoric in speeches and online, but there was a lasting impact on policy (Samari et al., 2021). For example, the expansion of the "Public Charge" rule, which deems many non-cash benefits, including Medicaid and the Supplemental Nutrition Assistance Program (SNAP), as penalties against immigrants for receiving permanent residency (Dawson & Sonfield, 2020), has had a chilling effect on immigrant care seeking behavior (Touw et al., 2021). Additionally, in October 2019, a presidential proclamation was released preventing immigrants from entering the country unless they could secure health insurance coverage within 30 days of arriving in the U.S. (Proclamation 9945 of October 4 2019, 2019).

Attributes of structural xenophobia like policy, media coverage, social barriers, and racialized legal status shape immigrant communities health and social well-being (Asad & Clair, 2018). Racialized legal status refers to a discredited social position based on race-neutral legal classifications that disproportionately affects racial and ethnic groups (e.g., undocumented legal status) (Asad & Clair, 2018). Undocumented immigration status may lead to poor health outcomes by decreasing health care access and utilization (Castañeda et al., 2015; Hacker et al., 2015; Page et al., 2020). For example, undocumented immigrants are often prevented from accessing public benefits, such as Medicaid, and an estimated 60% of undocumented immigrants do not have health insurance coverage (Ayón et al., 2020). Undocumented immigrants have a greater fear in accessing public benefits, and immigrant women may avoid seeking medical care for their U.S.-born citizen children in case it exposes them to the risk of deportation (Wallace et al., 2019). Similar to systemic racism (Braveman et al., 2022), systemic xenophobia is upheld by structures like the U.S. Immigration and Customs Enforcement (ICE) agency, which has planted deep distrust and fear in immigrant communities (Hacker et al., 2011). For example, ICE raids have led immigrant community members to avoid necessary treatment even if they are experiencing symptoms of COVID-19 (Lopez & Holmes, 2020). Even immigrants with legal status avoid enrolling in government assistance programs and insurance for their children in the case it will hinder their chance of renewing their visa or applying for citizenship (Fleming & Bryce, 2018).

This climate of anti-immigrant policy and subsequent immigration enforcement has made a significant impact on health care utilization among immigrants (Perreira et al., 2018). Latinx immigrants generally avoid using health care because of fears related to immigration concerns (Galletly et al., 2022; Held et al., 2020). There is evidence suggesting that Latinx immigrants have lower utilization rates of preventive screening services when compared to other racial or ethnic groups, including both immigrants and US-born individuals, due to disparities in insurance status and perceived barriers (Macias Gil et al., 2020; Carrasquillo & Pati, 2004). Although immigrants are not required to disclose documentation status to receive health care services, lower utilization rates of screening services could also be attributed to lack of awareness of safety net sources available for health care or the inability to obtain insurance because of undocumented immigration status (Carrasquillo & Pati, 2004). Further, intensified anti-immigrant rhetoric is associated with a significant

decrease in the number of completed primary care visits among a group of primarily undocumented patients in 2015, when compared to Medicaid patients (Nwadiuko et al., 2021).

While health risk factors are apparent for both immigrant men and women, there is a relevant gender dimension with immigrant women often deemed more vulnerable because of the increased likelihood of being in socially disadvantaged situations, such as poverty, with little social and economic protection (Dias et al., 2010). Latinx women experience barriers to health care and the prevalence varies widely depending on nationality and nativity (Petruzzi et al., 2021). Even if they are able to access health care services, discrimination is central to Latinx immigrant women's experiences of health care. Previous research shows that immigrant women from Mexico, South America, and Central America report experiencing discrimination because of their ethnicity when seeking care (Sheppard et al., 2014). The most common type of interpersonal discrimination was their providers' lack of communication and the fact that they did not listen to them, while the next common type of discrimination was the manner in which providers treated them, which was often rudely or disrespectfully (Sheppard et al., 2014).

Disparities in healthcare utilization among foreign-born Latinx women persist because of the way structural inequities are compounded by competing priorities – motherhood, in particular. Research has shown that during COVID-19, mothers carried a heavier burden of the provision of childcare during the pandemic than compared to fathers (Zamarro & Prados, 2021). Immigrant women may be particularly vulnerable to childcare burdens because of the intensification of disrupted or weak social support networks during COVID-19. Previous research shows that family fragmentation is a significant source of stress for immigrant women, particularly those who are undocumented and experience disruptions in social support due to deportation, inability to travel, and other issues related to racialized legal status (García, 2018; Magaña & Hovey, 2003). In addition to the disproportionate burden of COVID-related illness and related social and economic concerns for immigrant women and their families, reproductive stigma, violence, and injustice for Latinx immigrant women, in particular, was brought into the spotlight during the pandemic after nurse Dawn Wooten voiced concerns about the number of forced sterilizations of immigrant women at the Irwin County Detention Center in Georgia (Ghandakly & Fabi, 2021). This added dimension of the structural environment contributed to growing mistrust in providers and in the health care system for Latinx immigrant women.

During the COVID-19 pandemic, in NYC, with the aid of vaccine incentives and mandates, 55% of Latinx populations, including U.S. and foreign-born individuals, were fully vaccinated as of October 2021 compared to 51% of white residents (O'Connell-Domenech, 2021). However, even with this promising evidence, there is concern that there are additional disparities for Latinx immigrants, with 31% of foreign-born populations identifying as Latinx in NYC (Warren, 2019). As many Trump era immigration policies remain in place and COVID-19 vaccination among Latinx communities remains a priority, it is critical to understand the role of xenophobia and racism in impeding access to health care among Latinx immigrants as described through their own accounts. The purpose of this study is to explore how racism and xenophobia exacerbate existing social inequalities and shape Latinx immigrant women's health care experiences during COVID-19 in the five boroughs of NYC. Further, the study explores how discrimination has impacted immigrant women's ability to engage in and utilize health care services during the pandemic.

2. Methods

2.1. Data collection

The data for this study are a subsample (N = 21 foreign-born Latinx women) of an overall study that includes participants who are immigrant women (N = 45) from any country outside of the U.S. who reside in the

five boroughs of NYC. Semi-structured, in-depth interviews were conducted with immigrant women from all five boroughs to ensure geographical representation of residence throughout the city. Qualitative interviews were chosen as the methodology to allow for an exploration of participants' experiences, perceptions, and personal insights during the COVID-19 pandemic. Study investigators constructed the interview guide and revised based on an initial set of interviews to ensure participants were given the opportunity to detail the impact of experiences of racism and the COVID-19 pandemic on their daily lives. Interviews were conducted via Zoom video-based calls or phone calls, based on participant preference. Interviews ranged from 25 minutes to 66 minutes and were audio recorded. Each participant received an information sheet about the study prior to the interview and provided verbal consent at the beginning of each interview to allow for audio recordings to take place.

Participants were given a \$50 Amazon gift card for their participation in the study. After each interview, the interviewer compiled fieldnotes to document demographic information, general observations, main and emerging themes, as well as topics to include in subsequent interviews. A translator and transcriber were hired to translate and subsequently transcribe the Spanish interviews to English. The English recordings were then run through audio transcription software and written transcripts were manually compared with the audio recording for accuracy.

2.2. Participant recruitment

Recruitment for the study began in August 2020 and interviews were completed by March 2021. Initial sampling was done with the help of community-based organizations (CBOs) that work and provide services for immigrant communities. A range of CBOs and not just healthcare organizations were specifically targeted to include immigrant women who may or may not be currently accessing health care services. Additional participants were recruited via snowball sampling and referral from those who initially participated. To be eligible for the study, women needed to be ages 18–49 years old, identify as an immigrant from any country outside of the U.S., and be able to speak either English or Spanish. Participant age was capped at 49 years old to include foreign-born women up to standard reproductive age (15–49 years old). There was no capacity to conduct interviews in an indigenous language, and all interviews were conducted in either English or Spanish, depending on participant preference.

The subsample for this analysis is comprised of 21 foreign-born Latinx women. Data collection was capped at 21 participants for this specific subpopulation of immigrant women, as theoretical saturation had been reached. There were seven interviews that took place over Zoom and 14 interviews that took place over the phone. Participants immigrated from various countries, including Colombia, the Dominican Republic, Ecuador, Peru, Honduras, Mexico, and Nicaragua. Employment for each participant varied and was grouped in one of four major categories: 1) Unemployed/unstable employment, defined as a participant who is currently not working, may be willing and able to work for pay, may currently be available for work, and/or has actively been searching for work; 2) Domestic work or food service, which includes jobs such as housecleaning, laundry service, restaurant cook, or babysitting; 3) Health care or finance, which includes positions in health care marketing or financial firms; and 4) Independent, which includes jobs in independent sales. The participants' responses to questions on demographic characteristics, including participants' age, marital status, country of origin, employment status, monthly household income, level of education completed, number of children, and residence is listed in Table 1. The heterogeneous sample offers insight into diverse Latinx immigrant women experiences in NYC.

2.3. Data Analysis and interpretation

To begin the coding process, two members of the study team coded five randomly selected transcripts using a line-by-line approach to identify prominent themes and patterns. Thematic codes based on

Table 1

Sample characteristics (means (SE) or %) for COVID-19 immigrant NYC study.

Latinx Immigrant Women (N = 21)		
Key Variables	N	% or Mean (SD)
Current Age (years)	21	36.5 (5.15)
20 - 29	2	9.5
30 - 39	14	66.7
40 - 49	5	23.8
Country of Origin		
Colombia	2	9.5
Dominican Republic	6	28.6
Ecuador	2	9.5
Honduras	2	9.5
Mexico	7	33.3
Nicaragua	1	4.8
Peru	1	4.8
Marital Status		
Married/Longtime Partner	7	33.3
Cohabiting	2	9.5
Single	4	19.0
Separated/Divorced/Widow	8	38.1
Monthly Household Income		
\$0 - \$500	2	9.5
\$501 - \$1000	6	28.6
\$1001 - \$2000	8	38.1
\$2001 - \$5000	2	9.5
>\$5001	3	14.3
Level of Education Completed		
Primary or middle school	6	28.6
High school	4	19.0
Technical school	2	9.5
Bachelor's degree	6	28.6
Graduate degree	3	14.3
Employment		
Unemployed/unstable employment	11	52.4
Domestic work or food service	5	23.8
Health care or finance	2	9.5
Independent	3	14.3
Residence		
Bronx	8	38.1
Manhattan	5	23.8
Brooklyn	1	4.8
Queens	6	28.6
New Jersey	1	4.8
Number of children		
None	4	19.0
One	3	14.3
Two	8	38.1
Three	5	23.8
Four	1	4.8

existing literature were also integrated into the codebook. Team members then conducted three additional rounds of codebook revisions until they reached a high level of agreement about the meaning and application of codes. The final codebook contained 41 parent codes and numerous subcodes or child codes. The 21 de-identified transcripts were uploaded and coded using Dedoose qualitative analysis software. Data were analyzed using a constant comparative method (Glaser & Strauss, 1967), which is an iterative process of continuously reviewing data alongside emergent themes and patterns until core categories and relationships between categories are identified. Once all transcripts were coded, specific themes and narratives emerged around participants' experiences of discrimination in accessing health care services.

3. Results

3.1. Overview

This study focused on the impact of racism on Latinx immigrant women's health care access and care seeking behaviors in NYC during COVID-19. Four distinct themes emerged: structural inequalities, discriminatory health care experiences, victimization within public institutions, and overcoming discrimination in health services.

3.2. Structural inequalities and health care access

3.2.1. Economic barriers to health care access

Structural inequalities are often leveraged as markers of structural racism and discrimination, and when participants were asked to describe their experiences of accessing health care, they discussed multiple barriers rooted in structural inequality. The women were particularly affected by the economic consequences of the pandemic because of their intersecting identities as Latinx immigrants and for the majority, working mothers. Most participants worked in informal labor sectors, such as paid domestic work, and at the onset of the pandemic, lost their jobs or experienced greatly reduced hours. Others felt forced to give up their employment in order to take care of their children and to manage their children's online education.

"... Due to the pandemic I had to leave my job of 14, 15 years for my children, for school...because my girl had classes at home, and what I earned was not enough to pay...another person to teach her" (IMW 16, 38 years-old).

As a result, women struggled to pay rent and to afford essential items, alongside extensive periods of food insecurity. Given the increased challenges of meeting basic, everyday needs, such as standing in line for food assistance for over five hours, women found it difficult to prioritize health care. As one woman explained:

"Yes, in many different situations, it is not only getting sick or being sick, going to a hospital, it is knowing if you're working, not working, knowing how you are going to pay your rent, how you are going to be able to eat, in other words, there are many things that come to your mind" (IMW 11, 45 years-old).

Women frequently discussed how these economic barriers were exacerbated by their lack of legal status, including their inability to access government benefits, such as the COVID-19 stimulus aid, unemployment benefits, or state health insurance. While participants were not required to disclose their immigration status during interviews, 28.5% of participants self-disclosed their undocumented immigration status while explaining the barriers they have encountered when accessing social services and health care. Across interviews, the lack of access to public health insurance was particularly problematic and was identified by women as a critical aspect of social inequality and marginalization. As one woman shared:

"There is a saying...that we are like oranges – we come here, they squeeze us and send the peel back to our country to die because all our strength, youth, health stays here and we don't even have health insurance, we do not have a living wage, and we are not respected as people" (IMW 13, 39 years-old).

3.2.2. Lack of affordable and accessible childcare

In addition to economic, social, and legal barriers, participants also brought up challenges related to the inaccessibility of affordable childcare, which weighed significantly on how they perceived realistic options for seeking health care services during COVID. This was a particular obstacle for single mothers and women with a limited social support. Eleven out of the 21 participants (over 50%) were single, separated or divorced and were the sole or primary breadwinner of their households. Although participants were not asked explicitly in interviews if they had experienced domestic violence, five participants (nearly 24%) voluntarily divulged a history of intimate partner violence; all five of these participants discussed ongoing mental and/or physical health sequelae as a result of the abuse, including, in three cases, sequelae experienced by their children.

Some participants described cancelling health care appointments because of new restrictions within health care facilities that prohibited children from accompanying their parents. Others described using home

remedies to treat ailments (including symptoms of COVID) instead of seeking out health care services because of the difficulties of finding, and affording, childcare. This was also a considerable source of stress and anxiety for women who worried about what would happen to their children if they had to be hospitalized. One participant relayed:

"That has been the most difficult part even when the pandemic started, I thought: I am going to die, I will never see them, I am medically fragile, what would happen if I have to be isolated, what would happen to my daughter, who would I leave her with, so many worries" (IMW 10, 39 years-old).

3.2.3. Increased risk of exposure to COVID-19

Women articulated ways that structural social and economic inequalities increased their risk of COVID-19 exposure, sometimes expressing frustration or a sense of injustice for being blamed or held responsible, as immigrants, for the burden or risk. Citing disparities in household conditions, for example, or the necessity of engaging in undesired mobility, they drew attention to the limitations that immigrant communities face in their capacity to mitigate risk. One woman relayed:

"Because we are in a poor neighborhood, so to speak, where we have no way to overcome it, we do not have the possibility of living like citizens do, in an apartment alone with a partner and children. Unfortunately, Hispanics are always sharing an apartment where two or three families live and it is impossible to quarantine when there are only two rooms or one room, so we don't have that possibility here, we go to the overcrowded supermarket, the laundromats. Going to a public place to do your things is not the same as being at home and having a washing machine" (IMW 15, 45 years-old).

This study reveals that structural inequities are a daily dimension of Latinx immigrant women's lives and socioeconomic conditions force many women and their families to put themselves at risk for COVID-19 to maintain financial stability in addition to the limitations immigrants face while trying to find inclusive and supportive economic opportunities.

3.3. Discriminatory health care experiences

Participants' accounts reveal ways that experiences and perceptions of discrimination within institutional settings shaped their decisions about whether or not to seek health care services during COVID-19. Women's reluctance to seek out care to address physical and social needs during the pandemic often centered around beliefs that they would receive low quality health care services. This was most commonly discussed in terms of language barriers and lack of insurance, as primary markers of immigrant status, alongside associated feelings of exclusion, embarrassment, and fear.

One participant described her reluctance to seek care during COVID, saying that she tends to feel "afraid, ashamed and frustrated going to ask for help" for herself (IMW 1, 31 years old). When she began experiencing COVID symptoms, she eventually sought care in the emergency department, although she felt "embarrassed to talk to people" and asked her daughter to translate. Later on in the interview, she shared her perception that anti-immigrant discrimination had increased significantly during COVID. She stated:

"I don't want to go to a hospital and have them stare at me and ask me what's going on with me and being pregnant without being able to communicate because sometimes I ask do you speak Spanish or is there someone who speaks Spanish, and I ask them in English and they say, 'here is this stupid woman, coming to a hospital and she can't speak English.'"

Other forms of discriminatory treatment included feelings of exclusion and being denied access to care. This form of discrimination was emotionally distressing, and sometimes caused women to avoid seeking

care at specific facilities. One woman describes being denied care, without any explanation from the health facility staff:

“Yeah, that’s what I was saying, that there was a [therapy] center around here where I went, and they saw my shape, my race, I don’t know if it was because of that or what happened, I know they didn’t pay attention to me. and I left” (IMW 7, 32 years-old).

Although women described avoiding health care facilities because of the risk of contagion, the fear of being denied access to care or receiving low-quality care for COVID symptoms was equally cited as a primary reason for opting out of health care services. One participant described her decision to self-treat at home, rather than going to the hospital, when she became ill, based on information she had seen or heard from others in her community:

“... We think that we may have had coronavirus symptoms, but we didn’t go to the hospital or anything, we just stayed home... from all of the news or the social media posts that I saw where they talked about that at the hospital, they wouldn’t care for you, they gave priority to American citizens, so us as undocumented people, we weren’t given that priority, so undocumented people were dying more, so that is what really made us afraid to go to the hospital... when I heard that I got scared and said, ‘why would I go if they’re not going to treat me.’” (IMW 2, 34 years-old).

Some participants described incidents in which they or their loved ones were sent home from the hospital or told not to seek care from a health care facility, which they commonly attributed to xenophobia. Such accounts reveal ways that women’s experiences of health care responses to COVID-19 were often colored by perceptions of discrimination. One woman described what happened when her ex-husband sought care for COVID:

“He had a bad experience because he went and he says that they just attended to someone who was sicker and passed him by, and they did the covid test and gave him an injection and sent him home. So, I really felt bad because I said like, why is this happening, I don’t know if it’s because we are immigrants and like I said, our neighborhood was the covid epicenter, so I think they also discriminated against him thereas far as we know, I think the others had insurance because they ask you if you have insurance, even the ambulance came to bring them and they were taken and given quick attention, and they definitely did not want him in the hospital, they just did the test, gave him the injection and sent him home” (IMW 13, 39 years-old).

Several participants described similar experiences as influencing their decisions to opt out or actively avoid health care institutions, and stated that they believed discriminatory experiences had worsened during the COVID-19 pandemic. One participant explained the devastating consequences that result from health care mistreatment:

“A man who lived with them – when they went to the clinic, they were sent medicine they were quarantined at home – and the man who got sick, their friend who got sick, they took him to the doctor where they went, but when they took him there, the doctor asked him for Medicaid and he didn’t have Medicaid, so the doctor sent him to the hospital, and when he got to the hospital, his brother said that they intubated him because he had the virus, but he died...so it’s true that yes, there is a lot of discrimination now in the pandemic because they did not give equal care to people who are illegal, to immigrants” (IMW 8, 37 years-old).

Many women opted to delay or cancel health care services, unless absolutely necessary. While for many, this amounted to skipping an annual physical exam or rescheduling a dental cleaning, in some cases, it had more serious implications for the health and wellbeing of women and their families. Some participants described deteriorating conditions from unaddressed health problems.

Such was the case of one woman, a 35-year-old (IMW 9), who began experiencing heavy bleeding during the pandemic due to untreated uterine fibroids. Another woman (IMW 7, 32 years-old) had to delay important neurological exams for her son who had been showing behavioral abnormalities. Some women discussed putting off health concerns so long that they eventually had to seek emergency services to address deteriorating conditions. Among those women and their family members who had experienced COVID symptoms, many reported the use of home remedies (e.g., teas) and other forms of self-treatment.

3.4. Victimization in public institutions

Women’s engagement with health care services was also impacted by experiences and perceptions of victimization, including violence perpetrated within state institutions. They worried not only about receiving subpar services, but also about hostile treatment and criminalization, which may lead to a “spillover effect” on how they thought about and engaged health care services during COVID-19. One woman, for example, described a traumatic experience while in an immigrant detention center, which had a lasting effect on subsequent institutional encounters:

“I am not American...they took me to an extreme detention for childbirth, I was pregnant and there were a lot of complications, I lost my baby, and I was very affected at that time” (IMW 7, 32 years old).

Today, in the context of COVID, one of her greatest fears of contracting the illness is that she would be forced to leave her children alone in the house and, as a result, they would be taken away by the state. Recounting a trip to the emergency room after she suffered an asthmatic attack, she shared:

“The most painful thing was that I thought I had the coronavirus, and my little children, my children depend on me...I have [no family close by] to say look, come quickly, grab my children, come and take them, because no, they would have already been taken by the police, you know. Because they even go through proceedings, you know, the children don’t have – once the city takes them, you see, so that is a very big fear for me – that my children will be taken away from me.”

Others described the uncertainty around using public health benefits, including Medicaid, because of the potential consequences for legal status, including threat of deportation.

“When you start to fill in the information sometimes I don’t [put] much because there may be people who may call immigration or something, there are bad people, because sometimes they do things anonymously, so no ...” (IMW 9, 35 years-old).

The fear of being threatened with deportation or risking one’s legal status was serious enough for some participants to avoid seeking care, even in dire circumstances, as one participant recounts:

“I just collected food at the door and he went outside and so he felt like, he was with fever for 14 days so I was like, you have to go and take a test. But because they don’t have the immigrant status, like a [legal] status, so they don’t want to go to the hospital” (IMW 43, 30 years-old).

For some, even leaving the house to seek out health and social services during the pandemic became a considerable challenge because of fear of generalized discrimination and violence against immigrant communities – including violence perpetrated by the police. As one participant shared:

“Yes, right now, lately I’m even scared of the police, I don’t go out, truthfully, I just went out because I needed food, shopping, but lately I’m scared of even running into a policeman, it scares me because of so much news that I have seen when I go outside the house and,

maybe I'm close to a police officer, I better get away from where he is and go somewhere else ..." (IMW 3, 38 years-old).

This sheds light on how challenges spurred by COVID are influenced by the broader sociopolitical context and policy climate (e.g., structural racism and structural intersectionality).

3.5. Overcoming discrimination in health services

While discrimination was extremely prevalent for many of the Latinx immigrant women, some participants described affirming and inclusive health care interactions resulting in positive experiences. As one respondent explains, some of the most affirming health care experiences occur when the provider is able to communicate effectively in the right language with the patient:

"Yes, they are Spanish speaking, that's why – to give you the opportunity to express yourself in your language without feeling stressed out that the other person can't understand you" (IMW 6, 43 years-old).

Other participants described health care experiences that emphasized cultural sensitivity and made the patient feel more comfortable. One woman described the reason she enjoys going to her clinic:

"The doctor doesn't speak Spanish, but they make an effort to explain everything to you, she asks you questions in Spanish, which makes you feel good as a patient, because even though it's not her language either, she tries to make you feel comfortable as a patient, asking you questions in Spanish, so for me the clinic where I go is very good" (IMW 2, 34 years-old).

For many participants, financial resources may be limited for health care expenses, especially if they do not have health insurance coverage. One woman explained the supportive environment she experienced at a sexual and reproductive health care clinic given the typical barriers to health care:

"It's like a place where you go and they cover you for free exams, and medication, and everything. So, I used to go there and that was a really an amazing place to go because they didn't make you questions about your insurance or whatever. And they give you like a full service depends on what you need" (IMW 44, 29 years-old).

4. Discussion

This study provides important information on Latinx immigrant women's perspectives on racism and health care in NYC, during the COVID-19 pandemic, and at the end of the Trump Administration, after enduring four years of xenophobic policies. Foreign-born Latinx women experienced discrimination from the structural level, through social and economic inequalities, to the individual level, through discriminatory health care experiences and the fear of victimization in social institutions. This aligns with research that has found that Latinx women experience barriers for accessing health care across multiple levels (Morales-Alemán et al., 2020). One of the key implications of these disparities in care is the negative effect on immigrant women's capacity to seek health care services that was deepened during a time of need and a global pandemic. Further, as a result of racism and xenophobia fueling existing structural inequities, Latinx immigrant women who experienced structural socioeconomic inequities prior to the pandemic had negative health care-seeking behaviors (i.e. avoiding health care), which were further exacerbated during the COVID-19 pandemic.

The COVID-19 pandemic also brought attention to the disproportionate burden of disease on minoritized racial and ethnic communities in the U.S. However, the data portraying the increased susceptibility of these underserved communities in the U.S. is proof of structural racism,

which is historically rooted and perpetuated by inequitable systems (Bailey et al., 2017; Hardeman et al., 2022). It is likely that residents in low-income, underserved communities, who are disproportionately people of color and immigrants, will rely on public transportation to travel to work, work in precarious jobs, and lack forms of self-protection (i.e., isolation, living in less crowded spaces) – all factors that increase their risk of contracting COVID-19 (Devakumar et al., 2020; Zalla et al., 2021). This theme was well-documented among many of the study participants, particularly for those who did not want to expose themselves to COVID-19, but were forced to perform jobs in-person due to their financial instability.

Our study findings reveal ways that structural inequalities were exacerbated by the pandemic through women's need to address competing priorities, which were often directly linked to gendered responsibilities and vulnerabilities. It became harder to prioritize health care needs when many women were concerned about their children's day-to-day survival. This new uncertainty was often expressed as economic and financial instability, a social inequality tied to structural racism. Existing research indicates that financial uncertainty is even more common during economic downturns and in situations when anti-immigrant sentiments are higher, both consequences of the COVID-19 pandemic (García, 2018). Women also cited the lack of childcare as a concern to seek health care services. It is well known that mothers carried a heavier burden on caretaking responsibilities during the pandemic compared to fathers (Zamarro & Prados, 2021). For Latinx immigrant women in this study, social isolation and a lack of social support for childcare were structural barriers to seeking health care. This aligns with past research that shows immigrant stress is tied to disruptions in social support due to issues related to legal status, such as the deportation of a family member (García, 2018; Magaña & Hovey, 2003), as well as a disproportionate burden of COVID-related illness and death (Ross et al., 2020).

Findings from this study also reveal that foreign-born women felt even more vulnerable when seeking care during the COVID-19 pandemic because of the fear and/or concern that many immigrants were not given the same quality of care as non-immigrants. Previous studies validate this fear by showing how immigrants experience a lower standard of medical care if they need treatment for COVID-19 (Zalla et al., 2021). Many Latinx immigrant women discussed their perception of barriers and perceived discrimination in accessing health care services through first-hand experience; others described how they would not take other family members or kids to health care settings because of their own experiences of discrimination; and other women suggested they avoided health care settings because of the anticipation of this discrimination. Individuals who have experienced discrimination in the past may be more hesitant to seek health care services in the future because of the increased threat of discrimination exposure (Rivenbark & Ichou, 2020). Anticipated discrimination has also been linked directly to psychological and cardiovascular stress responses, which have serious implications for long-term health outcomes (Sawyer et al., 2012). Evidence of anticipatory discrimination is clear in many of the women's responses to avoiding seeking health care, especially when they anticipated experiencing racism due to their language or race. Health care professionals who offered services in Spanish or clinic staff who reassured immigrant patients they would not release their documentation status were more successful in overcoming racism-related barriers for immigrant communities to access care.

Undocumented Latinx women emerged as considerably more vulnerable. It is established that immigrants with temporary or permanent legal status have access to public benefits and labor mobility, while undocumented immigrants lack civil and labor protections (Asad & Clair, 2018). Lack of legal status and employment in low-paying jobs prevents access to health care coverage and care (Cleaveland & Waslin, 2021). Study participants expressed concerns about their documentation status and were fearful in seeking health services that could jeopardize their legal status. Much of this fear stems from changes to the "Public Charge"

rule and perceptions of enhanced immigration enforcement. Immigrants without legal status avoid medical and social services, due to a “chilling effect” or fear of risk to their legal status or even deportation (Castañeda et al., 2015; Fleming, Lopez, Mesa, et al., 2019; Friedman & Venkataramani, 2021; Lopez & Holmes, 2020; Perreira et al., 2018). Even prior to the public charge ruling, the collective burden of federal anti-immigration policies caused many immigrants to avoid government-funded programs (Dawson & Sonfield, 2020). One study found that one in seven adults in immigrant families said they or a family member avoided a federal program, such as SNAP or Medicaid, in 2018 because they feared it would affect their future green card status (Bernstein et al., 2019). This theme appeared in participant anecdotes when detailing their reasons for avoiding health institutions. In fact, some immigrant women chose to avoid seeking health services altogether, even if it meant their health condition would worsen as a result.

On an individual level, discrimination related uncertainty and stress was coupled with COVID-19 related uncertainty and stress to shape the experiences of Latinx immigrant women and their propensity to seek and receive health care. For the foreign-born Latinx participants, uncertainty operated across multiple dimensions, including dimensions specific to the immigrant experience, like experienced and anticipated racism, financial instability, legal status, and fear of deportation, and dimensions specific to COVID-19 including experienced racism, financial instability, fragmented social networks because of social distancing, and childcare burdens. For immigrant communities, issues like racism, legal status, lack of access to public services, and deportation have created uncertainty and stress among immigrants for a long time. The COVID-19 pandemic merely surfaced and exacerbated this existing uncertainty and stress with clear implications for health care seeking behaviors. Immigrant women who have witnessed their family members being removed by immigration enforcement authorities experience negative economic, psychosocial, and health effects (Fleming, Lopez, Ledon, et al., 2019). Furthermore, mistrust in the health system was exacerbated due to the lingering effects of anti-immigration rhetoric and policies and the general climate towards immigrants at the start of the pandemic (Touw et al., 2021). This study provides a deeper look into the structural inequities experienced by Latinx immigrant women in their health care interactions and health-seeking behaviors during the COVID-19 pandemic.

The study findings highlight opportunities to implement advocacy and policy changes in order to address the widespread structural inequities experienced by Latinx immigrant women when accessing health care services. Strategies to aid Latinx immigrant women in seeking health care services should address these barriers and incorporate public health approaches that are equitable and culturally relevant. Strategies could include providing accurate information on accessible health care services throughout immigrant communities, namely, to minimize fear of jeopardizing legal status, providing accurate information on changes in immigration policy throughout immigrant communities, and hiring and training culturally competent, bilingual patient navigators and health care providers in community-based organizations and health care settings. Widespread structural xenophobia and related uncertainty caused Latinx immigrant women to avoid seeking health care services out of fear of effects on their legal status; therefore, information on accessible community health centers that provide services for free for undocumented immigrants is crucial (Castañeda et al., 2015). Many Latinx immigrant women avoided seeking health care, or applying for publicly funded programs, for fear of becoming a “public charge.” While the 2019 Public Charge Final Rule is no longer in effect (Public charge, USCIS, 2022), this information needs to be rapidly disseminated through immigrant communities in order to prevent further fear of accessing government-funded programs. Lastly, a noticeable source of discrimination stemmed from the prevalence of language barriers and demeaning and exclusionary interactions with providers when receiving care. Community-based organizations and health centers must prioritize training staff and clinicians to provide culturally relevant care, and hire translators to assist patients during medical visits to create a welcoming and safe space.

This study is not without some limitations. One limitation was the difficulty of outreach due to the ongoing COVID-19 pandemic. The pandemic restrictions limited in-person recruitment, so the virtual outreach approach depended on CBOs and spanned a period of seven months and may have missed certain groups of available, willing participants. CBOs were overstretched during the COVID-19 pandemic and had limited availability to pass along information and assist with recruitment. Despite this barrier, CBOs were key to partners for the study, facilitating recruitment of a substantial group of immigrant women from different countries of origin over time. While the interviewers were able to conduct interviews in both Spanish and English, there was a digital barrier, with many participants opting to participate in the interview via telephone, rather than videoconferencing. Despite these limitations, the data gleaned from these interviews was rich and provides valuable information on the distinct challenges for foreign-born Latinx women in NYC, particularly with regards to experiences of racism and health care.

5. Conclusion

There are increasing calls for research that centers immigrant health care experiences and health outcomes as products of structural racism and resulting social inequalities (Dennis et al., 2021). This study shows how multi-level forms of racism and subsequent inequities shaped foreign-born Latinx women's health care interactions and experiences during the COVID-19 pandemic. This study highlights the inaccessibility of health care services and avoidance of health care among Latinx immigrant women because of experiences of racism inside and outside of the health care setting. These narratives suggest that the COVID-19 pandemic coincided with years of structural xenophobia including xenophobic policy, which exacerbated existing barriers for immigrant women in seeking health care services. Overall, these findings provide additional support to existing literature citing xenophobia, racism, and discrimination as a barrier to health care utilization, while also addressing a gap in research focused on the distinct challenges Latinx immigrant women face when seeking health care services during the COVID-19 pandemic. This study emphasizes how racism shapes how Latinx immigrant women seek health care, which is vital to address in order to increase health care accessibility among immigrant populations and improve population health overall.

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Ethical statement

Ethical approval was obtained through the Columbia Irving Medical Center Institutional Review Board (IRB-AAAT2404).

Declaration of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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